5101:3-3-20.2 **Nursing facility (NF) and intermediate care facility for the mentally retarded (ICF-MR): medicaid cost report.**

The NF and ICF-MR medicaid cost report must be filed in accordance with the requirements set forth in rules 5101:3-3-20 and 5101:3-2-20.1 of the Administrative Code. Appendix A of this rule is the cost report which shall be issued to NF and ICF-MR providers at least sixty days before the due date of the cost report for each cost reporting period.

Effective: 09/12/2003

R.C. 119.032 review dates: 06/25/2003 and 09/12/2008

CERTIFIED ELECTRONICALLY

Certification

09/02/2003

Date

Promulgated Under:	119.03
Statutory Authority:	RC 5111.02
Rule Amplifies:	RC 5111.01, 5111.02, 5111.26
Prior Effective Dates:	12/30/77, 8/3/79, 7/1/80, 1/19/84, 3/29/85, 12/31/87 (Emer.), 3/30/88, 7/1/88, 12/20/88 (Emer.), 3/18/89, 12/28/89 (Emer.), 3/22/90, 10/1/90 (Emer.), 12/20/91(Emer.), 3/19/92, 6/30/92, 12/1/92, 6/26/93, 12/30, 93 (Emer.), 3/18/94, 12/31/94, 12/28/95, 3/20/97 (Emer.), 12/17/98

TN #03-017 APPROVAL DATE APR - 5 2004
SUPERSEDES
TN #98-19 EFFECTIVE DATE 9/12/03

AMENDED
APPENDIX
5101:3-3-20.2

Ohio Department of Job and Family Services
MEDICAID COST REPORT

Nursing Facilities and Intermediate Care Facilities for the Mentally Retarded

Type of Cost Report Filing pursuant to OAC Rule 5101:3-3-20 and 5101:3-3-24 (Please check one of the following)

_____ 4.1 Year-End _____ 4.3 Change of Provider Agreement _____ 4.5 Closed Facility _____ 4.7 Capital
_____ 4.2 New Facility _____ 4.4 Rate Reconsideration _____ 4.6 Amended

This cost report must be received or postmarked pursuant to OAC Rule 5101:3-3-20 except for state operated ICFs-MR. Failure to file timely will result in reduction of the current prospective rate by two dollars ($2.00) per patient per day. This rate reduction shall be adjusted for inflation in accordance with ORC Section 5111.26 (A) (2). Read instructions before completing the form. PLEASE ROUND TO THE NEAREST DOLLAR FOR ALL ENTRIES MADE ON THIS COST REPORT. When completed, submit to Ohio Department of Job and FamilyServices, Bureau of Long Term Care Facilities, Reimbursement Section, 30 East Broad Street, 33rd Floor, Columbus, Ohio 43215-3414

Provider Name	Medicaid Provider Number	Medicare Provider Number
Complete Address: Address (1) Address (2) City State of Ohio Zip Code	Federal ID Number ODH ID Number County	Period Covered by Cost Report From: Through:

TYPE OF CONTROL (Please check one of the following)

Proprietary for Profit ____ 1.1 Individual ____ 1.2 Partnership ____ 1.3 Corporation ____ 1.4 Other: specify control Corp. Name Address (1) Address (2) City State Zip Code	Type of Facility _____ 1. Nursing Facility _____ 2. ICF-MR Facility Is Facility a Unit of a: ____ a. Hospital ____ b. Rehabilitaion Center ____ c. Other : Specify
Voluntary Nonprofit ____ 2.1 Church ____ 2.2 Other: Specify Control ____ 2.3 Church Corporation	Name and Address of Owner of Real Estate Zip Code
Nonfederal Government ____ 3.1 State ____ 3.4 City - County ____ 3.2 County ____ 3.5 Hospital ____ 3.3 City ____ 3.6 Other: Specify Control	Name and Address of Owner (Operator) of Business Zip Code

ALL PATIENTS	Medicaid Certified Beds Only (1)	Total Facility Licensed Beds (2)
1. Licensed beds at beginning of period		
** 2. Licensed beds at end of period		
3. Total bed days available		
4. Total inpatient days		
5. Percentage of occupancy (line 4 divided by line 3 X 100)		
6.1 Indirect allowable days (greater of line 4 or .85 X line 3)		
*6.2 Capital allowable days (greater of line 4 or .95 X line 3)		
OHIO MEDICAL ASSISTANCE PROGRAM PATIENTS		
7. Total patient days (from Schedule A-1, line 13, column 5)		
8. Utilization (line 7 divided by line 4, col. 1 X 100)		

*EXCEPT AS PROVIDED IN OAC RULE 5101:3-3-53 (for Nursing Facilities)
*EXCEPT AS PROVIDED IN OAC RULE 5101:3-3-86 (for ICFs/MR)
**IF LINE 2 IS DIFFERENT FROM COL. 1, LINE 1, NOTE DATE OF CHANGE __________ AND NUMBER OF BEDS INVOLVED __________
**IF LINE 2 IS DIFFERENT FROM COL. 1, LINE 1, NOTE DATE OF CHANGE __________ AND NUMBER OF BEDS INVOLVED __________
**IF LINE 2 IS DIFFERENT FROM COL. 1, LINE 1, NOTE DATE OF CHANGE __________ AND NUMBER OF BEDS INVOLVED __________

JFS 02524 (REV. 10/2002)

TN #03-017 APPROVAL DATE APR - 5 2004
SUPERSEDES
TN #98-19 EFFECTIVE DATE 9/12/03

CERTIFICATION BY OFFICER OF PROVIDER

Provider Name	Medicaid Provider Number	Reporting Period From: Through:

In accordance with the Medicaid Agency Fraud Detection and Investigation Program rule 42 CFR 455.18, all cost reports submitted to ODJFS will be certified as follows:

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER FEDERAL AND STATE LAWS AND PUNISHED BY FINE AND/OR IMPRISONMENT.

I hereby certify that I have read the above statement and that I have examined the accompanying cost report and supporting schedules and attachments prepared for (name of provider) _____, number _____ for the cost report period beginning _____ and ending _____ and that to the best of my knowledge and belief, it is a true, accurate, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions, except as noted.

Signature of Owner, Officer, or Authorized Representative of Provider(s)	Date of Signature
Print or Type Name of Owner, Officer, or Authorized Representative of Provider(s) (Last) (First) (M.I.)	
Title	Telephone Number Area code ( ) Fax Number Area Code ( )

Report Prepared by (Company)	
Report Prepared by (Individual) (Last) (First) (M.I.)	Title
Address	
City, State, Zip Code	
Telephone Number for Person Preparing Cost Report Area Code ( )	Fax Number Area Code ( )

Location of Records or Probable Audit Site	Telephone Number for Audit Contact Person Area Code ( ) County
Address _____	
City _____	State _____ Zip Code _____

NOTARIZED

Subscribed and duly sworn before me according to law, by the above named officer or administrator this _____

day of _____ 20____ at _____, county of _____, and state of _____.

Signature of Notary

_____

TN #03-017 APPROVAL DATE APR - 5 2004
SUPERSEDES
TN #98-19 EFFECTIVE DATE 9/12/03

SUMMARY OF INPATIENT DAYS

Schedule A-1

Provider Name	Medicaid Provider Number	Reporting Period From: Through:

Note: All data must be stated on a service date (accrual) basis. For example, January data would include only the applicable days and billings for services rendered during January. NFs must report each medically necessary leave day and limited absence as 50% of an inpatient day. Please refer to rule 5101:3-3-59 of the OAC for details.

Month	Number of Medicaid Certified Beds (1)	Patient Days (Per Census) for Medicaid Patients Only				Non-Medicaid Eligible Patients			Inpatient Days for Patients (sum of col.5-8) (9)
		Authorized Days (2)	Hospital Leave Days* @ 50% (3)	Therapeutic Leave Days* @ 50% (4)	Total Medicaid Days (sum of col. 2-4) (5)	Private Days (6)	Medicare Days (7)	Veterans and Other Days (8)	
1. January									
2. February									
3. March									
4. April									
5. May									
6. June									
7. July									
8. August									
9. September									
10. October									
11. November									
12. December									
13. TOTAL (sum of lines 1 through 12)	[redacted]								
					to JFS 02524 Schedule A line 7	[redacted]			to JFS 02524 Schedule A line 4, col. 1

* CONSULT THE OHIO ADMINISTRATIVE CODE RULE 5101:3-3-59 (NFs) AND 5101:-3-3-92 (ICF-MRs) FOR AN EXPLANATION OF THE DIFFERENCE BETWEEN HOSPITAL AND THERAPEUTIC LEAVE DAYS.

TN #03-017 APPROVAL DATE APR - 5 2004

SUPERSEDES

TN #98-19 EFFECTIVE DATE 9/12/03

DETERMINATION OF MEDICARE PART B COSTS TO OFFSET Schedule A-2

Provider Name	Medicaid Provider Number	Reporting Period From: Through:

Instructions: List GROSS CHARGES for residents days shown in Schedule A-1 and Attachment 4. GROSS CHARGES must be reported from the uniform charge structure that is applicable to all residents.

SECTION A	Description (1)	Medicare Part B Primary Payer is: Medicaid (2)	Medicare Part B Primary Payer is: Other (3)	Private (4)	Medicare Part A Services (5)	Veteran and Other (6)	Medicaid (7)	Total Revenue (sum of cols. 2-7) (8)
1a	Medical Supplies Revenue							
1b	Percentage (line 1a, each col. 2-7 divided by total on line 1a col. 8)							100%
2a	Medical Minor Equipment							
2b	Percentage (line 2a, each col. 2-7 divided by total on line 2a col. 8)							100%
3a	Enteral Feeding Revenue							
3b	Percentage (line 3a, each col. 2-7 divided by total on line 3a col. 8)							100%
4	TOTAL (Sum of 1a through 3a)							

SECTION B: COSTS	(1)	MEDICARE PART B OFFSET CALCULATIONS: Medical Supplies (2)	Medical Minor Equip. (3)	Enterals (4)	Total Offset (5)
5	Percentage of Medicare Part B Charges where primary payer is Medicaid (from Sch A-2, col. 2, applicable line b)				
6	Costs (from Schedule B-1, column 3, lines 1 and 4 and Schedule C column 3 line 11)				
7	Costs to be offset (line 5 times line 6). Offset costs in col. 4 on applicable cost repoirt lines identified in line 6 of this section.				

SECTION C: INDIRECT COST - OFFSET		
8	Indirect costs (Schedule C line 63 column 3 less Sch. C lines, 18, 25, 34, 35, 36 and 55 col. 3)	
9	Total costs (total of Sch. B-1 line 19, B-2 line 56, C line 63, D lines 11, 13, 19, 30, and 44.)	
10	Line 8 divided by line 9	
11	Costs offset (from line 7 column 5 above)	
12.	Indirect cost to be offset (line 10 times line 11) offset costs on Schedule C line 47 column 4	

TN #03-017 APPROVAL DATE APR - 5 2004
SUPERSEDES
TN #98-19 EFFECTIVE DATE 9/12/03

SUMMARY OF COSTS

Schedule A-3

Provider Name	Medicaid Provider Number	Reporting Period From: Through:

	REIMBURSABLE COSTS	Reference Schedule Line (1)	Sub Total (2)	Total Cost (3)	Allowable Patient Days (4)	Filed Cost Per Diem (Col 3 / 4) (5)
	OTHER PROTECTED COSTS					
1.	Other Protected Costs use allowable patient days Sch A line 4 Col 1	B-1 line 26 Col 7				
	DIRECT CARE COST CENTER					
2.	Direct Care Cost use allowable patient days Sch A line 4 Col 1	B-2 line 56 Col 7				
	INDIRECT CARE COST CENTER					
3.	Indirect Care Cost use allowable patient days Sch A line 6.1 Col 1	C line 63 Col 7				
	CAPITAL COST CENTER **COST OF OWNERSHIP**					
4.	Assets Acquired Group A	D line 11 Col 7				
5.	Assets thru Change of Ownership Group B	D line 19 Col 7				
6.	**Total Cost of Ownership** (sum of lines 4 and 5)					
	RENOVATIONS COST CENTER					
7.	Renovations Group A	D line 13 Col 7				
8.	**TOTAL CAPITAL COST** (Sum of lines 6 and 7) use allowable patient days Sch A line 6.2 Col 1					
	EQUITY					
9.	Return on Equity	E-1 line 36 col 5				
10.	**TOTAL REIMBURSABLE COSTS** (sum of lines 1, 2, 3, and 8) Col 3					
11.	**TOTAL FILED COST PER DIEM** (sum of lines 1, 2, 3, 8, and 9) Col 5					

RECONCILIATION OF COSTS

	Schedule / Line #	Total (1)	Adjustments: Increases (Decreases) (2)	Adjusted Total (3)	(Opt.) Allocated Adjusted Total (4)
12.	B-1/26	col 3	col 4	col 5	col 7
13.	B-2/56	col 3	col 4	col 5	col 7
14.	C/93	col 3	col 4	col 5	col 7
15.	D *	col 3	col 4	col 5	col 7
16.	Totals	$ (A)	$ (B)	$	$
17.	Less Non-Reimbursable from Schedule C Page 3 line 92			col 5 ( )	col 7 ( )
18.	Total Reimbursable			$ (C)	$ (C)

* Summary of Schedule D lines 11, 13 and 19.
(A) Agrees to Total Expenses per Working Trial Balance.
(B) Agrees to Attachment 2, line 40, column 4, and Schedule A-2, lines 7 and 12, column 5.
(C) Agrees to Schedule A-3, line 10, column 3.

NOTE: All cost data should be rounded to the nearest whole dollar.

TN #03-017 APPROVAL DATE APR - 5 [illegible]
SUPERSEDES
TN #98-19 EFFECTIVE DATE 9/12/03

OTHER PROTECTED COSTS

Schedule B-1

Name of Facility	Medicaid Provider Number	Reporting Period From: Through:

	OTHER PROTECTED COSTS	Chart of Acct	Salary Facility Employed (1)	Other/ Contract Wages (2)	Total [Col 1+Col 2] (3)	Adjustments Increases (Decreases) (4)	Adjusted Total [Col 3+Col 4] (5)	Alloc. Ratio **** (6)	Allocated Adjust. Total [Col 5xCol 6] (7)
	MEDICAL SUPPLIES								
1.	Medical Supplies - medicare billable	6000							
2.	Medical Supplies - medicare non-billable	6001							
3.	Oxygen - Emergency stand-by	6003							
4.	Medical Minor Equip. - medicare billable	6005							
5.	Medical Minor Equip. - medicare non-bill.	6006							
6.	TOTAL Medical Supplies (sum of lines 1 through 5)								
	PRIOR AUTHORIZED MEDICAL EQUIP.								
7.	Prior Authorized Medical Equip.	6010							
	UTILITY COSTS								
8.	Heat, Light, Power	6020							
9.	Water and Sewage	6030							
10.	Trash and Refuse Removal	6040							
11.	Hazardous Medical Waste Collection	6050							
12.	TOTAL Utility Costs (sum of lines 8 through 11)								
	PROPERTY TAXES								
13.	Real Estate Taxes	6060							
14.	Personal Property Taxes	6070							
15.	Franchise Tax (Attach FT 1120)	6080							
16.	TOTAL Property Taxes (sum of lines 13 through 15)								
	GOVERNMENT MANDATED FEES								
17.	Government Mandated Assessments/Fees	6090							
17a.	Franchise Permit Fees	6091							
17b.	Total Government Mandated Fees (sum of lines 17 and 17a)								
	HOME OFFICE COSTS **								
18.	** Home Office Costs/Other Protected **	6095							
	PAYROLL TAXES, FRINGE BENEFITS & STAFF DEVLOPMENT								
19.	Payroll Taxes - Other Protected	6054							
20.	Workers Compensation - Other Protected	6055							
21.	Employee Fringe Benefits - Other Protected	6056							
22.	EAP Administrator - Other Protected	6057							
23.	Self Funded Programs Adm. - Other Protected	6058							
24.	Staff Development - Other Protected	6059							
25.	**TOTAL Payroll Taxes, Fringe Benefits, & Staff Develop.** (sum of lines 19 thru 24)								
26.	**TOTAL Other Protected Costs (sum of lines 6,7,12,16,17b,18, & 25)**								

** HOME OFFICE COSTS INSTRUCTIONS: **

Home office costs are to be entered on line 18 only. They are not to be distributed to any other line on this schedule.

**** If ratios of allocation are used, limit the precision to four places to the right of the decimal.

Note: All cost data should be rounded to the nearest whole dollar.

JFS 02524 (REV. 10/2002)

TN #03-017 APPROVAL DATE APR - 5 2004

SUPERSEDES

TN #98-19 EFFECTIVE DATE 9/12/03

Schedule B-2
1 of 2

DIRECT CARE COST CENTER

Provider Name	Medicaid Provider Number	Reporting Period From: Through:

DIRECT CARE COST CENTERS	Chart of Acct	Salary Facility Employed (1)	Other/ Contract Wages (2)	Total [Col 1+Col 2] (3)	Adjustments Increases (Decreases) (4)	Adjusted Total [Col 3+Col 4] (5)	Alloc. Ratio **** (6)	Allocated Adjust. Total [Col 5xCol 6] (7)
NURSING AND HABILITATION / REHABILITATION								
1. Medical Director	6100							
2. Director of Nursing	6105							
3. RN Charge Nurse	6110							
4. LPN Charge Nurse	6115							
5. Registered Nurse	6120							
6. Licensed Practical Nurse	6125							
7. Nurse Aides	6130							
8. Activity Director	6135							
9. Activity Staff	6140							
10. Recreational Therapist for NFs	6145							
11. Program Specialist for ICFs-MR	6150							
12. Program Director	6155							
13. Habilitation Supervisor for NFs	6160							
14. Habilitation Supervisor for ICFs-MR	6165							
15. Habilitation Staff	6170							
16. Psychologist	6175							
17. Psychology Assistant	6180							
18. Respiratory Therapist	6185							
19. Social Work/Counseling	6190							
20. Social Services/Pastoral Care	6195							
21. Qualified Mental Retardation Professional	6200							
22. Quality Assurance	6205							
23. Consulting and Management Fees-Direct Care	6210							
24. Other Direct Care - Specify below	6220							
25. Home Office Costs/Direct Care	6230							
26. TOTAL Nursing and Habilitation / Rehab. (sum of lines 1 through 25)								
PURCHASED NURSING SERVICES								
27. Registered Nurse; Purchased Nursing	6300							
28. Licensed Practical Nurse; Purchased Nursing	6310							
29. Nurse Aides Purchased Nursing	6320							
30. TOTAL Purchased Nursing (sum of lines 27 through 29)								

Line 24 Other Direct Care - Specify Below

Account Title	Salary Column 1	Other Column 2
Totals must tie to line 24, Col 1 & 2		

**** If ratios of allocation are used, limit the precision to four places to the right of the decimal.

Note: All cost data should be rounded to the nearest whole dollar.

JFS 02524 (REV. 10/2002)

TN #03-017 APPROVAL DATE APR - 5 2004
SUPERSEDES
TN #98-19 EFFECTIVE DATE 9/12/03

Schedule B-2
2 of 2

DIRECT CARE COST CENTER

Provider Name	Medicaid Provider Number	Reporting Period From: Through:

	DIRECT CARE COST CENTER	Chart of Acct	Salary Facility Employed (1)	Other/ Contract Wages (2)	Total [Col 1+Col 2] (3)	Adjustments Increases (Decreases) (4)	Adjusted Total [Col 3+Col 4] (5)	Alloc. Ratio **** (6)	Allocated Adjust. Total [Col 5xCol 6] (7)
	NURSING FACILITIES ONLY NURSE AIDE TRAINING								
31.	In-House Trainer Wages	6400							
32.	Classroom Wages: Nurse Aides	6410							
33.	Clinical Wages: Nurse Aides	6420							
34.	Books and Supplies	6430							
35.	Transportation	6440							
36.	Tuition Payments	6450							
37.	Tuition Reimbursement	6455							
38.	Contractual Payments to Other NFs	6460							
39.	Registration Fees/Application Fees	6470							
40.	Employee Fringe Benefits	6490							
41.	TOTAL Nurse Aide Training - NFs (sum of lines 31 through 40)								
	ICFs-MR FACILITIES ONLY DIRECT CARE THERAPIES								
42.	Physical Therapist ICF-MR	6600							
43.	Physical Therapy Assistant ICF-MR	6605							
44.	Occupational Therapist ICF-MR	6610							
45.	Occupational Therapy Assistant ICF-MR	6615							
46.	Speech Therapist ICF-MR	6620							
47.	Audiologist ICF-MR	6630							
48.	TOTAL Direct Care Therapies ICF-MR (sum of lines 42 through 47)								
	NFs and ICFs-MR PAYROLL TAXES, FRINGE BENEFITS, & STAFF DEVELOP. (No Purchased Nursing)								
49.	Payroll Taxes - Direct Care	6510							
50.	Workers' Compensation - Direct Care	6520							
51.	Employee Fringe Benefits - Direct Care	6530							
52.	EAP Administrator - Direct Care	6535							
53.	Self Funded Programs Admin.- Direct Care	6540							
54.	Staff Development - Direct Care	6550							
55.	TOTAL Payroll Taxes, Fringe Benefits, & Staff Development (sum of lines 49 thru 54)								
56.	TOTAL Reimbursable Direct Care Cost (sum of lines 26, 30, 41, 48 and 55)								

**** If ratios of allocation are used, limit the precision to four places to the right of the decimal.

Note: All cost data should be rounded to the nearest whole dollar.

TN #03-017 APPROVAL DATE APR - 5 2004
SUPERSEDES
TN #98-19 EFFECTIVE DATE 9/12/03